

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151528		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2013	
NAME OF PROVIDER OR SUPPLIER VISITING NURSE SERVICE HOSPICE OF CENTRAL INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4701 N KEYSTONE AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 000	<p>INITIAL COMMENTS</p> <p>This visit was a federal and state Hospice complaint investigation survey.</p> <p>Complaint number: IN00122504 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey date: January 28, 2013</p> <p>Facility number: 007846</p> <p>Medicaid vendor number: 200141480A</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor, Team Leader David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Visiting Nurse Service Hospice of Central Indiana is in compliance with the Indiana State Rules for hospice licensure IC 16-25-3 and the Conditions of Participation 42 CFR 418.106(d) Administration of drugs and biologicals and 42 CFR 418.62 Licensed professional services as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 4, 2013</p>			L 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.